Becoming a New Jersey Medicaid Provider

In order to enroll as a New Jersey Medicaid provider **(Behavioral Health and Intensive In-Community)** for the Division of Child Behavioral Health Services (DCBHS) program, you will need to complete an enrollment package, which consist of the following forms:

- ➔ Signature Authorization Form
- ➔ Provider Application FD-20
- ➔ Provider Agreement FD-62
- ➔ Disclosure of Ownership and Control Interest Statement (CMS 1513)

Please note that for each county in which you have an office, you will need to complete an entire enrollment package. You will eventually receive a unique seven-digit provider number for each county office.

In an effort to assist you when completing these forms, we have compiled a list of the most common errors. If you have additional questions and can contact Unisys Provider Services at 1-800-776-6334 or the Division of Medical Assistance and Health Services' (Medicaid) Provider Enrollment Office at 609-588-2905.

SIGNATURE AUTHORIZATION FORM

1. The date is the date you are completing the form, since services are provided off-site for the Division of Child Behavioral Health Services, Behavioral Assistance and Intensive In-Community, the provider address should be the program office.
2. Provider Number will be your New Jersey seven-digit Medicaid provider number when you receive it. "Applying" should be added to that line when completing the form.
3. The signature(s) of the person or persons, who will be authorized to sign the claim forms, must complete this portion of the form. We **NEVER** accept stamped signatures or copied signatures on any forms. They all must be original signatures.

PROVIDER ENROLLMENT FD-20 APPLICATION

Remember, if you are providing services from multiple program offices, you may fill out one application for all the program offices in a county. If your program offices extend beyond one county, you must file an original application for each additional county.

1. Legal name or corporate name that coincides with the Federal tax identification number that was given to you…not a Social Security Number, unless you are a "sole proprietor".

2. Type of provider: Division of Behavioral Health Services

3. Business Name, example: What do you call your business?

4. Employer Tax ID Number: The 9 digit tax number given to you by the IRS when you started your business.

5. Telephone Number/Ext.: This should be a number where you can be reached if there are questions concerning the application.

6. Self Explanatory

7. Self Explanatory

8-13. Practice Address: Use program office.

14-18. Pay Address: This is where your checks and remittance advice will be sent.

19-23. Mail Address: This is for Newsletters/Approval letters, correspondence.

24. E-mail address.

25. Fax Number.

26a-26h. Not applicable.

27. Self-explanatory.

28. Services: For the Division of Child Behavioral Health Services please indicate whether you are providing Behavioral Assistance or Intensive In-Community services or both.

29. List the all the addresses (program sites) within that county. Remember that if you have an office in another county, you will need to complete another enrollment application.

29a. Not applicable.

30. Not applicable.

31-32. For the Division of Child Behavioral Health Services not applicable.

33. Approved by Medicare? For the Division of Child Behavioral Health Services not applicable

34 Self explanatory

35 Behavioral Assistance and Intensive Home In-Community list the name(s), and degree(s) of clinical supervisory staff and direct care staff as appropriate. Please submit a copy of your **current** license.

36 Self-explanatory. Answer all questions accurately and attach documentation if necessary. Please be advised that random applications could be sent to the Office of Program Integrity for further investigation.

37 Do you charge for goods and/or services? Here you check "all" and then provide us with you usual and customary fees..

38 "As needed" if you have specific operational hours…list them.

39 – 40 Self-explanatory

Don't forget to sign and date the FD-20 with an original signature.

PROVIDER AGREEMENT FD 62

The name of the business or name of provider goes on the Provider Name line. In spite .of being laced with a lot of legal terminology, this document outlines what you are agreeing to as a New Jersey Medicaid provider. Read it carefully, sign and date. Note that you can terminate this agreement at any time with a **written 30-day** notice to the Division.

CMS 1513 (HCFA 1513)
OWNERSHIP AND CONTROL INTEREST STATEMENT

The Ownership and Control Interest Statement (CMS 1513 or HCFA 1513) is **NOT** required to be completed by individual or group practitioners. It is however, a required Federal Government form that must be completed by any entity (something that exists as a particular and discrete unit, corporation). There are detailed instructions for completing this form.